Medicare Rx Update: May 26, 2006

There is less than one year left to get your NPI...don't risk disruptions to your cash flow
The National Provider Identifier (NPI) will be your standard unique identifier for electronically billing HIPAA covered entities. HIPAA requires the NPI to be used by health plans (e.g., Medicare, Medicaid, PDPs and other private health insurers), health care clearinghouses and health care providers that conduct electronic transactions, including pharmacists. NPIs will be required on all electronic claims sent on and after May 23, 2007. Every health care provider should obtain an NPI!

Getting your NPI is the first step in the process of meeting the compliance date. Once you have your NPI, you may need to modify your existing business processes to accommodate use of the NPI. You will also need to share your NPI with other health care providers with whom you do business.

Health care providers may obtain their NPI by applying on-line at (https://NPPES.cms.hhs.gov), requesting a paper application by calling the NPI Enumerator at 1-800-465-3203, or applying for a bulk enumeration, which allows an Electronic File Interchange Organization (EFIO) approved by CMS to obtain a number of providers' NPI.

Learn more about NPI and how to apply by visiting www.cms.hhs.gov/NationalProvIdentStand/ on the CMS website. A Countdown Clock is now available on this page to remind health care providers of the number of days left before the compliance date…you may also want to bookmark this page as new information and resources will continue to be posted. Please click here to see the press release: http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1870

Question of the Week:
CMS instructed Part D plans on May 5, 2006 that they are required to use the "best available data" to make changes to their systems when they have knowledge that a dual eligible beneficiary's cost sharing level is not correct. What does CMS mean by best available data?

Part D plans have flexibility to develop their own procedures for determining whether best available information is sufficient to change or update their systems to reflect appropriate cost sharing levels for dual eligibles. For example, with respect to dual eligibles who are community residents, a Part D plan may rely on the beneficiary showing the contracted pharmacy a current Medicaid card or on information provided by a state Medicaid office as proof of low-income subsidy status. Since the Part D plan will not know the exact subsidy level for the dual eligible beneficiary, it should default the enrollee to a $2/$5 benefit package.

For full benefit dual eligibles who are residents of long term care (LTC) facilities, a plan may develop procedures that rely on attestations from LTC pharmacy and facility personnel that certain residents who are enrollees of the plan are Medicaid eligible, have been or are expected to be residents of the facility for a full calendar month, and are under a Medicaid-covered stay. For LTC facility residents, Part D plans should rely on information that clearly indicates the elements necessary to confirm Medicaid eligibility and LTC facility admission dates for purposes of establishing a full calendar month of LTC facility residency. This could include location codes on billing transactions from the LTC pharmacies, in conjunction with the institutional attestations necessary to confirm Medicaid eligibility and LTC facility admission dates for a Medicaid-covered inpatient stay. As part of their procedures, Part D plans should keep appropriate records in order to reconcile low-income subsidy payments with CMS after the end of the contract year.

Sign up for the **PHARMACY_MMA-L** list to receive the Medicare Rx Update at:
http://new.cms.hhs.gov/apps/mailinglists/